**APPLICATION FOR**
**DISPROPORTIONATE SHARE HOSPITAL PROGRAM (DSH)**

This form is used to determine eligibility for the Disproportionate Share Hospital Program. All patients who do not have insurance should be screened using this form.

## Section I. Individual Information

The following information is used to determine if an individual who requests or has already received hospital services is eligible for Disproportionate Share Hospital services, or should be referred instead to the Department for Community Based Services (DCBS) to apply for Medicaid or KCHIP. Refer **all children aged 19 and under** to the DCBS office in the county of the individual's residence for a KCHIP eligibility determination.

1. Today's Date:_____

2. Patient's Name:_____

3. Street Address:_____

4. City:_____ State:_____ Zip Code:_____

5. Social Security Number (SSN) Explain:

   - the patient is not required to have or provide a Social Security Number
   - if provided, it will be used only to determine if the patient is currently receiving Medicaid
   - it will not be shared and will not be used for any other purpose

   Patient's SSN: (Required, if available)_____

6. Date of Birth: _____/___/_____ Patient's Gender:_____

7. Home Phone: _____ Work Phone:_____

8. Date(s) hospital services provided: ____/___ /_____ - ____/____/____

9. Married/Single:_____ 10. Name of Spouse:_____

11. Is the patient pregnant? Yes ☐ No☐

12. Is the patient a resident of Kentucky? Yes ☐ No☐

**"Resident" is defined as a person living in Kentucky and who is not receiving Public Assistance in another state.**

If the patient did not provide their SSN in response to the above question 5, then proof of residency in Kentucky is required. Examples of what can be accepted are:

- A copy of a rent receipt from prior 6 months
- A copy of a mortgage payment from prior 6 months
- Signed letter from family member or other community citizen stating residency status.

If the answer to question 14 is **"yes"**, go to question 15. If the answer to question 14 is **"no"**, **advise the patient that he/she does not meet the criteria for eligibility for DSH and complete Section V.**

13. Household members. List the name, relationship, and age of each person living in the household.

**Household Members**

| Name | Relationship | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

14. If the patient or household appear to be eligible for Medicaid or KCHIP:

- Check the potential category of eligibility as listed below in this question.
- Complete the rest of this application and give a copy to the patient.
- Explain to the patient the requirement to apply for Medicaid or KCHIP within 30 days, and report back within 120 days on whether the application:
  a) has been approved or
  b) has been denied or
  c) is still pending

Refer to DCBS to apply for KCHIP or Medicaid if the patient is (check one):

- o A child under 19
- o An adult with related children living in the home.
- o Pregnant
- o 65 years old or older
- o Either claims to be or is in fact permanently disabled or blind.

***Do not*** refer a patient to DCBS to apply for Medicaid or KCHIP if the individual:

- Received a denial of Medicaid or KCHIP within 30 days, or
- Is an adult under 65 without related children in the home (unless the adult may meet the permanent and total disability criteria for Medicaid).

If an individual claims to be permanently and totally disabled, refer the individual both to DCBS to apply for Medicaid and to the Social Security Administration to apply for SSI.

If a patient demonstrates that she/he has applied for Medicaid or SSI, but the application is still pending after the end of 120 days, approve the application.

15. Income Information:

Patient/Responsible Party's Employer: _____

Spouse's Employer: _____

Work Phone: _____

Total Gross Monthly Income:_____

Other Income:

Unemployment: _____ Soc. Sec.:_____ Worker's Comp:_____

SSI:_____ Other: _____

**Total Family Unit Gross Monthly Income: $_____**

15. Insurance Information (*continued*):

Health/Life Insurance:_____ Phone #:_____

Policy #: _____ Group #: _____

Policy Holder: _____ Relation to Patient: _____

16. List the patient's countable resources below. Countable resources include: a checking account, savings account, stock, bond, mutual fund, certificate of deposit, or money market account.

**Countable Resources**

| | **Bank Name** | **Balance/Value** |
|---|---|---|
| Checking | | |
| Savings | | |
| Certificate Of deposit | | |
| Money market | | |
| Mutual fund | | |
| Stocks | | |
| Bonds | | |
| Other (*Please Define)*: : | | |

***Total Health Bills Owed: $**_____
***Total Resource: $**_____
***Note: COUNTABLE RESOURCES SHALL BE REDUCED BY UNPAID MEDICAL EXPENSES OF THE FAMILY UNIT TO ESTABLISH ELIGIBILITY.**

**Other Information:**

Was date of service related to an auto accident? Yes ☐ No☐

Have you applied for and been denied Medicaid or KCHIP Benefits? Yes ☐ No☐

**SECTION II. Hospital Indigent Care Criteria**

1. An individual must meet all of the following conditions:
   a) The individual is a resident of Kentucky.
   b) The individual is **not eligible** for Medicaid or KCHIP.
   c) The individual is **not** covered by a 3rd party payor.
   d) The individual is **not** in the custody of a unit of government which is responsible for coverage of the acute care needs of the individual.
   e) The individual meets the following income and resource criteria (*see next page*):

| Household Size | Resource Limit | 100% of the Poverty Level (Monthly Income Limit)* | 100% of the Poverty Level (Annual Income Limit)* |
|---|---|---|---|
| 1 | $2,000.00 | $908.00 | $10,890.00 |
| 2 | $4,000.00 | $1,226.00 | $14,710.00 |
| 3 | $4,050.00 | $1,545.00 | $18,530.00 |
| 4 | $4,100.00 | $1,863.00 | $22,350.00 |
| 5 | $4,150.00 | $2,181.00 | $26,170.00 |

**Add an additional $3,820.00 for each additional person**

***Note- Income limits are effective April 1, 2011**

2. **All income** of a family unit is to be counted and a family unit includes:
   a) The individual;
   b) The individual's spouse who lives in the home;
   c) A parent or parents of a minor child, who lives in the home;
   d) All minor children who live in the home.

3. Related and nonrelated household member(s) who do not fall into one of the groups listed above shall be considered a separate family unit.

4. **Countable resources are limited to** cash, checking and savings accounts, stocks, bonds, certificates of deposit, and money market accounts.

5. Countable resources may be reduced by unpaid medical expenses of the family unit to determine eligibility
   .

## SECTION III. Certifying Accuracy of Information

I hereby agree to furnish the Hospital all necessary information to allow them to determine my need to receive financial assistance for health care services received. I agree that the Hospital will be provided with or may obtain all documents necessary to verify my current income, employment status, and resources; and that failure to supply requested information within thirty (30) working days is grounds for denial of my application for assistance. I also agree to notify the Hospital immediately of any change of address, telephone number, employment status, or income.

I agree to allow the Hospital representative to determine eligibility, and pursue state and federal assistance with Medicaid, KCHIP and DSH.

I certify that the information provided on this application is correct to the best of my knowledge and belief. I understand that if I give false information or withhold information in accepting assistance, I may be subject to prosecution for fraud. I understand that I have a right to request a fair hearing if I am dissatisfied with any action taken on my application. I understand that I must contact the hospital to make a hearing request.

_____ _____
Individual or Responsible Party's Signature Date

_____ _____
Hospital Employee's Signature Date

Does the individual appear to qualify for Medicaid or KCHIP? Yes ☐ No ☐

**If yes, then refer the individual to the DCBS office located in the county that the individual resides. The individual should take a copy of this form with her/him to the DCBS office.**

**SECTION IV. Refusal to Apply for Medicaid**

The individual or his responsible party shall sign below if he refuses to apply for Medicaid.

I refuse to apply for Medicaid or KCHIP coverage. I understand that this refusal may result in me being billed for any services performed.

_____ _____
Individual's or Responsible Party's Signature Date

**SECTION V. Indigent Care Denial**

The individual does not meet the criteria for indigent care for the following reason:

_____ The individual is not a resident of Kentucky.
_____ The individual has been referred to apply for Medicaid or KCHIP, but has refused to apply.
_____ The individual already receives or has been approved for Medicaid or KCHIP.
_____ The individual has been referred to apply for Medicaid or KCHIP, but has not shown at the end of 30 days that the application was filed.
_____ The individual has been referred to and applied for Medicaid or KCHIP within 30 days, but has not shown at the end of 120 days that
- the application has been denied or
- the application is pending

_____ The individual did not provide within 120 days information needed to verify income, resources or employment status.
_____ The individual is covered by the following third party payor:
_____ The individual is in the custody of the following unit of government which is responsible for coverage of the acute care needs of the individual:
_____ The household income of $_____ is too high.
_____ The household resources of $_____ are too high, even when reduced by unpaid medical bills.

The individual believes that he/she is eligible for indigent care for the following reason *(please write below):*

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**SECTION VI. Hearing Request**

The individual may request a fair hearing within 30 days of this determination either by:

- Signing and dating the hearing request below, and returning a copy of this application to the hospital, or
- Sending a letter to the hospital requesting a hearing.

Hearing requests must be post-marked or hand-delivered within 30 days of the date below to:

Name or Department:_____
Hospital:_____
Address:_____

I request a hearing on this denial. I believe I am eligible for indigent care.

Patient Signature:_____ Date:_____

The hospital shall conduct a fair hearing within 30 days of receiving the individual's hearing request.

**SECTION VII. Hospital Records**

This determination was made by:

_____ _____
Hospital Employee's Signature Date

_____ _____
Witness Date

**RETAIN A COPY OF THIS APPLICATION IN THE PATIENT'S RECORDS.**
**THIS DETERMINATION IS VALID FOR A PERIOD OF SIX MONTHS UNLESS THE INDIVIDUAL'S FINANCIAL SITUATION CHANGES.**

Hand or mail a copy of this application to any individual that has been denied coverage. Include a cover letter stating the reason for denial, and that the individual has 30 days to appeal.

If the individual has been referred to apply for Medicaid or KCHIP, attempt to contact after 30 days to see whether the individual has applied.

If an individual has applied for Medicaid (including SSI) or KCHIP, attempt contact at 60, 90 and 120 days to see whether the application was approved or denied.

If information needed to verify income, resources or employment is missing, attempt contact at 30, 60 and 90 days to remind the patient. Assist persons with disabilities as needed.

If a Medicaid or SSI application has been made but is still pending after 120 days, you may approve this application.